AFFIDAVIT OF DOMESTIC PARTNERSHIP

Declaration
We, _____ (Enrollee) and _____ (Domestic Partner) certify that we are domestic partners in accordance with the following criteria and affirm that on or about _____, _____, we entered into a Domestic Partner relationship and are living together in a Domestic Partner relationship.

Domestic Partner Criteria
We declare, under penalty of perjury that we meet all of the following criteria:

- We are eighteen years of age or older and unmarried; and
- We are of the same sex as each other; and
- We are not related by blood in any manner that would prohibit legal marriage; and
- We have assumed mutual obligations for the welfare and support of each other; and
- We have been sharing a common residence and living together as a couple in the same household for at least twelve months; and
- We are each other's sole domestic partner, and neither person has had a different partner less than twelve months before the date of this affidavit.

Change in Domestic Partner Status
We acknowledge that, in the event we no longer meet one or more of the criteria set forth above, we will no longer be considered Domestic Partners and will immediately file an Affidavit of Termination of Domestic Partnership form with the BSA Benefits Office. The Partner, and any dependents of the Domestic Partner will no longer be eligible for coverage under the BSA benefits programs, but may elect temporary continuation of coverage under the continuation of coverage provisions of COBRA.

Other Acknowledgements
We declare, under penalty of perjury, that all of the information we have provided on this form is true and correct.

I, the Enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my domestic partner and such partners' dependents and disciplinary action up to and including termination of employment and possible charges of fraud.

Employee Information

_____
Name (printed)

_____
Social Security Number

_____
Date of Birth

_____
Street Address

_____
City, State, Zip Code

_____
Signature

_____
Date Signed

State of _____
County of _____
Sworn to before me this day of
_____, 20_____
Notary Public

Domestic Partner Information

_____
Name (printed)

_____
Social Security Number

_____
Date of Birth

_____
Street Address

_____
City, State, Zip Code

_____
Signature

_____
Date Signed

State _____
County of _____
Sworn to before me this day of
_____, 20_____
Notary Public

DEPENDENT TAX AFFIDAVIT
FOR ENROLLING A DOMESTIC PARTNER IN THE BSA HEALTHCARE PROGRAMS

Declaration

I, _____ (Enrollee), certify that my domestic partner, _____ (Domestic Partner), fully qualifies as my dependent under Internal Revenue Code (IRC) Section 152(a)(9).

In addition, the following child(ren) of such Partner fully qualify as my dependent under Internal Revenue Code (IRC) Section 152(a)(9).

_____ (Domestic Partner's Child 1)

_____ (Domestic Partner's Child 2)

_____ (Domestic Partner's Child 3)

_____ (Domestic Partner's Child 4)

I understand that if my partner's dependent status or the status of such Partner's child(ren) under IRC Section 152(a)(9) changes at any time during the year, I will be responsible for reporting and paying tax on any resulting imputed income. If this should occur, I will notify the BSA Benefits Office immediately. I, the Enrollee, understand that any false or misleading statement made in order to receive benefits for which I do not qualify will subject me to financial responsibility for any benefits paid on behalf of my domestic partner and such partners' dependents and disciplinary action up to and including termination of employment and possible charges of fraud.

Employee Information

_____
Name (printed)

_____
Social Security Number

_____
Signature

_____
Date Signed

State of _____
County of _____
Sworn to before me this day of
_____, 20_____

_____
Notary Public